Seizure Action Plan and Medication Authorization

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant, and for interscholastic and intramural sports only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a qualified school personnel to administer medication. Medications must be in the original properly labeled container.

School		**District**		**School Year**	**2023-2024**
Student Name				**DOB**	
Describe seizure type			**Triggers/warning signs**		
Typical Seizure duration/frequency/post-ictal period			**Medication Allergies** ☐ NKDA ☐ Yes: (describe)		

HEALTH CARE PROVIDER MEDICATION AUTHORIZATION

Medication: Name/Dose/Route/Time/Frequency

PRN ☐ at onset of seizure *or* ☐ seizure lasting more than_____minutes.

Controlled drug? ☐ Yes ☐ No **Medication side effects**_____

- **Call 911** upon administration of emergency medication. **☐ Yes ☐ No**
- **May student return to school activities after return to baseline? ☐ Yes ☐ No** - Dismiss with parent/guardian
- **Field Trip management:** Student may participate in fieldtrip without emergency seizure med. **☐ Yes ☐ No**
- **Authorization for self-carry ☐ Yes ☐ No** **Self administration-Not applicable**
- **Medication to be administered** (1 year limit) from (MM/DD/YY)_____ to (MM/DD/YY)_____

Prescriber's Name/Phone/Fax/Address:

Prescriber'signature_____**Date** (MM/DD/YY)_____

Parent/Guardian Authorization: I approve the administration of the above ordered medication and seizure management procedures by qualified school employees. I also give my consent for exchange of information between the prescribing health care provider and the school nurse, as needed for safe administration of this medication and implementation of this seizure plan. I have received, reviewed and understand the above information.

Parent/Guardian Name_____**Signature**_____**Date (MM/DD/YY)**_____

Phone: Home_____Mobile_____Work_____**Email**_____